

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

IN RE: OPTOMETRIC CARE TECHNICAL ADVISORY COMMITTEE
MEETING

May 6, 2021
1:00 P.M.

(All Participants Appeared Via Zoom or Telephonically)

APPEARANCES

Matthew Burchett
CHAIR

James Sawyer
Steve Compton
Gary Upchurch
Karoline Munson
TAC MEMBER PRESENT

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APPEARANCES
(Continued)

Veronica Cecil
Lee Guice
John Hoffmann
MEDICAID SERVICES

(Court Reporter's Note) At the request of DMS, all other participants appearing via Zoom or telephonically will not be listed under Appearances?

AGENDA

Call to Order

Approval of February 2021 TAC Minutes

Follow-up from last MAC Meeting:

- Reported that KYHealth.net has gone live with the missed appointment check box. Instructions on where/how to mark a missed appointment?
- Discussion on Recoupments

Follow-Up from last TAC Meeting - Do optometrists have to contract with KHIE?

Discussion on PA/Post Authorizations information in each MCO's portal

Avesis: If billing a 92xxx codes as medical and will refraction be paid if it is an approved medical code.

March Vision: Follow-up from last TAC discussions

- Contracting: time table to credential, contracting for exams only?
- Billing issues: taxonomy Code, payment time table, portal issues
- Any frame kit news?

Discussion with all MCOs and Vision Contractors: OMDs and ODs billing to the same entity.

Next TAC Date Scheduled: August 5th at 1pm

1 MS. CECIL: Hi, everyone. This
2 is Veronica Cecil with Kentucky Medicaid. Sharley is
3 not able to join, so, we have another staffer that's
4 handling the hosting.

5 And I want to say we have three
6 what I call major meetings going on right now at the
7 same time. And, so, we've had to do our best to
8 allocate resources. So, hopefully, we have the staff
9 attending today that can be of support, but I did
10 want to note that.

11 DR. BURCHETT: I assume, because
12 I can't see who all is on - let me look here. Yes,
13 it looks like we have enough for a quorum. So, I
14 guess we can go ahead and get started, then.

15 As usual, I'm Dr. Burchett, the
16 Chair of the TAC, and I think most all the other TAC
17 members are on. I didn't see one that I thought was
18 missing there. So, we'll go ahead and get started.

19 I would like to say hello and
20 thank Dr. Munson for being on today. I know she has
21 been absent for a little while. So, good to see you
22 back.

23 And with that, the first item
24 on the agenda is approval of the minutes from the
25 February TAC meeting. Any of you all have any

1 questions on the minutes from the last meeting? If
2 not, I will have a motion to approve those.

3 DR. COMPTON: Steve Compton. I
4 move to approve.

5 DR. UPCHURCH: Gary Upchurch.
6 Second.

7 DR. BURCHETT: Any further
8 discussion on them? If not, then, all in favor of
9 approving the minutes from the last meeting, say aye.
10 And any opposed? Sounded like that was all of you.
11 Good deal.

12 Moving on to the rest of the
13 agenda, then, I'm going to let Steve take over right
14 here since he's our MAC representative and go over
15 the followup from the last MAC meeting they had.

16 DR. COMPTON: Okay. You caught
17 me off guard here a little bit.

18 The missed-appointment check
19 box, it's gone live. I think we've already reported
20 over fifty people for no-shows but I haven't seen
21 anything come out from DMS or KOA. Do our providers
22 know about this and how are they going to find out?
23 It seems to be working pretty well.

24 And the other question is, what
25 happens if somebody misses and they no show all the

1 time, is there a remedial effort made or where do we
2 go from here is I guess what I'm asking?

3 DR. BURCHETT: Steve, do you
4 know? I think on the dental side where this
5 originated, I think they actually have a code they
6 can code for reimbursement for no show.

7 DR. COMPTON: They do but
8 there's no CPT code for that and we can't use the
9 dental codes.

10 MS. CECIL: So, to clarify,
11 Medicaid does not allow to reimburse for a no-show,
12 for a missed appointment for any provider type.

13 DR. COMPTON: Right, but will
14 there be any - I mean, if you've got a patient that
15 habitually no shows with their providers and it shows
16 up on this report, is somebody going to contact them
17 and say, hey, look? What's the next step, I guess,
18 is what I'm asking?

19 MS. CECIL: I think we have
20 somebody from Policy on board, but you're correct. I
21 think the hope is that the information will be
22 shared, especially with the Managed Care
23 Organizations for any Managed Care members so that
24 they can outreach to find out what's going on, do a
25 little care management around why a person may be

1 missing appointments. It could be transportation,
2 child care. I think it will help us identify are
3 there barriers to accessing that care.

4 DR. COMPTON: We will generally
5 ask. If it's a pretty legitimate reason, we don't
6 even report it but some folks just don't show up.
7 And this is similar to the ER use. You track that.
8 If somebody is always going to the Emergency Room
9 when they could be going to their primary care, I
10 think there's some sort of mediation for that. It's
11 only been live a month.

12 MS. CECIL: That's right and we
13 don't have a lot of uptick in use of it yet and we
14 certainly hope that that will increase.

15 DR. COMPTON: I'm not sure
16 people know it's there.

17 MS. CECIL: I think Eddie
18 Newsome is on. Are you aware of how this has been
19 communicated to providers? I'm trying to see if he's
20 on.

21 MR. HOFFMANN: Veronica, this is
22 John Hoffmann. I think they're planning on putting
23 this on the DMS website promoting this. I think I
24 saw some language recently going through for
25 approval.

1 MS. CECIL: Okay. Thank you.
2 Let us take that back. I think there were plans to
3 put it on KyHealth.net, and we certainly shared it
4 with the MAC and TACs. We rely on you guys to share
5 it with your all's association and membership.

6 So, I believe that that was
7 shared that way but we'll go back and make sure that
8 there's a definite communication plan around it.

9 DR. BURCHETT: If that's
10 something you all would like for us to reach out to
11 our membership and association, we definitely could
12 do that.

13 MS. CECIL: Yes, absolutely.
14 That would be fantastic.

15 DR. BURCHETT: Okay.

16 DR. COMPTON: And the discussion
17 on recoupments, I'm a little bit at a loss there
18 other than we will occasionally get a recoupment two
19 years after the fact. Of course, you can't get it
20 from the patient at that point.

21 That may have been discussed at
22 the MAC meeting but I'm at a loss as to what was
23 said. Somebody else may have something to add here.

24 DR. BURCHETT: No, Steve. The
25 only thing I would say on recoupments that I can

1 think about would be like you just said. Sometimes
2 two and three years out, we will get a letter from a
3 provider (sic) saying they're going to recoup for
4 whatever reason. And like you said, we have no
5 ability to recoup that from the patients at all.

6 So, my question probably would
7 be how long can they go out for recoupments?

8 DR. COMPTON: We've got six
9 months for timely filing or a year or whatever it is.
10 I think there should be some sort of window that when
11 it's closed, it's closed.

12 And that may be a policy thing.
13 I don't know who sets that policy, if it's each MCO
14 or subcontractor or if that's set by DMS. I guess
15 that would be the place to start to see where the
16 rule comes from.

17 MS. CECIL: My understanding is
18 that the Managed Care Organizations, based on the
19 Department of Insurance regulations and statutes, are
20 permitted to go back two years.

21 So, the process for that
22 obviously - and what I'm not sure about is if that's
23 from date of payment - it may be - but the process
24 for that is elongated based on the two years. I
25 think time runs from when the provider is also

1 notified of that. So, they can go back two years
2 and, then, it may take a year or two or three
3 sometimes for the process to happen where they
4 requested records but there should be provider
5 notification along with that and, then, the
6 recoupment can occur. Of course, there's appeal
7 rights that go with that.

8 So, I do believe it's two years
9 from the date of, and, like I said, I don't know if
10 it's service or reimbursement.

11 DR. COMPTON: And I think ours
12 are typically eligibility.

13 MS. CECIL: So, keep in mind the
14 caveat to all that is CMS does require us, we are not
15 permitted to reimburse for services that - let me
16 rephrase that.

17 If the person is not eligible,
18 we're not allowed to reimburse for those services,
19 and retroactive eligibility does happen. It's
20 impossible to make that 100% without that.

21 Trust me, we completely
22 understand the burden that comes with that but we
23 have to follow CMS rules on that.

24 DR. COMPTON: It sounds like it
25 just is what it is kind of thing.

1 MS. CECIL: It is. That's why
2 we really try as much as possible to clean up
3 eligibility and to ensure on the front end that we're
4 catching and ensuring that people are eligible.

5 My understanding is that it
6 improved enormously over the years, especially around
7 incarceration. Does that mean it's perfect? No.
8 It's just not going to be a perfect system; but,
9 really, if a person is determined ineligible, we have
10 no choice but to recoup those funds.

11 DR. COMPTON: All right. Thank
12 you. That's all I've got, Matt.

13 DR. BURCHETT: Are you sure,
14 Steve?

15 DR. COMPTON: At least on this
16 topic.

17 DR. BURCHETT: Okay. Thank you,
18 Steve.

19 The next item it looks like is
20 follow-up from our last TAC meeting. We had a small
21 discussion about do we have to contract with KHIE,
22 and my memory is about as bad as it can be anymore,
23 but it seems like that was in some of our Medicaid
24 contracts that came out.

25 I've got a note here that we

1 talked with Nicole from Avesis on that.

2 MS. ALLEN: Yes, and the
3 contract language is actually in the MCO's contract
4 with DMS. You won't find that exact language within
5 your contact with Avesis.

6 And it's not that you must
7 register for the KHIE secure to transfer medical
8 records but it's that if you can register to
9 participate in the secure email system so that KHIE
10 gives you the ability to send secure emails and
11 receive secure emails from DMS but you don't have to
12 participate in the medical record transfer or medical
13 records-sharing option that KHIE offers.

14 I know most dental and some of
15 the eye care providers' operational systems are not
16 compatible with KHIE, but DMS is requiring, according
17 to the new contract, that you participate in the
18 secure email sharing.

19 DR. BURCHETT: Okay. I think
20 that answers my question on it because I wasn't
21 really sure what the thing was meant to get toward,
22 the point of the sign-up, the secure email.

23 Now, do we know if that
24 includes if our current medical records systems have
25 secure emails built in, we still have to sign up?

1 MS. ALLEN: I'll defer to DMS to
2 answer that question. I apologize. I don't know.

3 DR. BURCHETT: That's fine.
4 Thank you.

5 MR. MIRACLE: I can actually
6 jump in. And, I'm sorry, this is Dale with Avesis.
7 So, it's a direct secure messaging and that's direct
8 secure messaging with the KHIE site, with the
9 Kentucky Health Information Exchange site.

10 So, it's a separate system, so
11 to speak. So, your secure email is great but it's a
12 separate secure messaging system that you have to
13 register for.

14 DR. BURCHETT: Okay. That makes
15 it a little different, then, I guess. So, thank you.

16 MR. MIRACLE: You're welcome.

17 DR. BURCHETT: Any questions on
18 that from the TAC members?

19 DR. MUNSON: Yes, Matt. This is
20 Karoline. If that is in the contracts, is that
21 something that's going to change because the current
22 contracts have been thrown out and they're going to
23 rebid or is that something that is going to stay?

24 And that's probably a DMS
25 question, but I would be curious if that is

1 enforceable now if the contracts have been thrown
2 out.

3 MS. CECIL: So, the contracts
4 haven't been thrown out. What the Judge's Order said
5 is the requirement to rebid. So, current contracts
6 are still effective and enforced.

7 DR. MUNSON: so, then, when they
8 are rebid, this could be something that could change,
9 then?

10 MS. CECIL: For a future date,
11 yes.

12 DR. MUNSON: But for right now,
13 we are still bound by the current contracts that are
14 enforced?

15 MS. CECIL: That's correct.

16 DR. MUNSON: Which this is
17 included in.

18 MS. CECIL: That's correct.

19 DR. MUNSON: Okay.

20 DR. BURCHETT: Any other
21 questions?

22 MS. UNGER: This is Sarah with
23 KOA. Is there a timeline? Has this been
24 communicated to the optometrists in the state with
25 the contracts? If they have to do this, is there a

1 little bit more information or something on behalf of
2 the Association that can be sent out?

3 MS. ALLEN: I can try to take
4 the first shot at answering that.

5 The way that the contract is
6 written, it applies to newly-contracted providers.
7 So, existing providers, they may grandfather them in
8 at a later date, but at this point, the way the
9 contract language is written, it applies to new
10 providers.

11 Providers that are newly
12 credentialed, they have to register for KHIE secure
13 email within thirty days from their effective date,
14 from their effective credential date.

15 And, Veronica or anyone else
16 from DMS, please correct me if I misstated anything.
17 And if you're speaking, you may still be on mute.

18 MS. CECIL: I have nothing to
19 offer. That was correct.

20 DR. BURCHETT: Sarah, that might
21 be information that we probably need to check on with
22 the membership of the Association because I don't
23 remember me seeing any of that, but, of course, I'm
24 not a new provider. So, maybe I didn't see it
25 because of that.

1 MS. ALLEN: I can share that for
2 Avesis, in our new provider contract packets, there
3 is information regarding KHIE in the new
4 credentialing packet information that goes out to
5 providers.

6 DR. BURCHETT: Is that all
7 providers, Nicole?

8 MS. ALLEN: Yes.

9 MS. GILBERTSON: And that's
10 included. We have some messaging on that as well.

11 DR. BURCHETT: Okay. Fair
12 enough. Thank you all.

13 If there's no other discussion
14 there, then, I guess we'll move on to the next item
15 and that would be something that Dr. Munson has
16 brought to the group's attention. So, I'll let her
17 speak on that.

18 DR. MUNSON: Thanks, Matt. So,
19 this is not new. We've discussed this in the past to
20 try to get a better idea of either prior
21 authorizations or post authorizations for each MCO.

22 We've been told in the past,
23 it's on the portal. Just go to the portal and find
24 it.

25 I will give Avesis a shout-out.

1 Theirs is on the portal. It's easy to find. You
2 might need some reading glasses to look at it but it
3 has every detail you could ever want about all codes
4 that we would bill.

5 Now, going into the other MCOs'
6 websites was not nearly as fluid or easy to find.
7 So, what I would like for us as a provider group is
8 to have some easier access for this information and
9 something that is a little more transparent.

10 So, if we have a patient
11 sitting in our office that has Anthem MCO and needed
12 a bandage lens, we need to know if we can take care
13 of that patient and treat them appropriately for what
14 they need.

15 And I feel like if we can have
16 this information up front, that it would just help us
17 take better care of this patient population that
18 we're trying to serve.

19 So, Avesis is off the hook, but
20 for the other MCOs, I would really like a clear path
21 to finding this information as opposed to just
22 telling you it's on our portal.

23 MR. IRBY: Dr. Munson, this is
24 Greg from UHC. If I could just ask clarification
25 there. When you say this information, can you help

1 me understand what information is readily available
2 on Avesis' site that's not elsewhere?

3 DR. MUNSON: So, it's titled
4 Kentucky Medicaid Optometrists' Fee Schedule. And in
5 their fee schedule, it notes the CPT code. It notes
6 the reimbursement for place of service 11 which is
7 the office. It says global days. It has a column
8 that says prior authorization and it also has a
9 column that says post review. And, then, it also has
10 frequency and whether or not it's per eye.

11 So, within this I'm assuming
12 it's an Excel document, but within this spreadsheet,
13 I am able to see anything I would need to know for
14 each code that we are able to be billed and
15 reimbursed for.

16 MR. IRBY: Okay. Thank you for
17 that clarification. I appreciate it.

18 DR. MUNSON: So, not hearing any
19 of the other MCOs, I'm going to just ask if that's
20 something that we can have that information given
21 back to us.

22 I'm not sure if that is
23 something that I want to task it being emailed to
24 Sarah without her consent, but if that's an easier
25 way to have that emailed as opposed to just saying it

1 verbally, that would be fantastic. If there are
2 actual screen shots to walk through where it is on
3 the portal, that would be wonderful, too.

4 If it is not readily available,
5 then, I would ask that if there are those documents
6 available maybe in-house, that that would be
7 something that could be sent over and, then, that
8 would be something that can be disseminated to our
9 members, again, so this patient population can be
10 appropriately taken care of.

11 MR. RANDALL: Hi. This is
12 Jeremy Randall with Anthem. And I just want to say
13 that your request makes sense. I understand what
14 you're asking and we will respond accordingly.

15 DR. MUNSON: I appreciate that.

16 MS. MEDINA: This is Christina
17 Medina from EyeQuest. I think Jeremy must have been
18 on the same wave length there.

19 Most definitely, I think it
20 might just be a matter of just kind of a walk thru,
21 kind of putting a guide together on how to access our
22 information because we definitely have all of that
23 readily available but we want to make sure you guys
24 are familiar with those resources and know how to
25 access that information so that it can be convenient

1 and allow for the best experience as you all service
2 the membership. So, we'll definitely take that as a
3 takeaway.

4 DR. DAVIS: This is John Davis
5 from EyeQuest. Just to follow up, right now, that
6 information is available in the office reference
7 manual anytime, but putting it on the portal in a lot
8 more detail, that's not a bad idea.

9 We'll look into that for sure,
10 but right now it's available to you just looking at
11 our ORM. It's a very short list of services that
12 require a PA.

13 DR. MUNSON: So, where would an
14 office reference manual live, then? Is that
15 something that an insurance and billing department
16 would have or is that in a packet when people sign
17 up?

18 DR. DAVIS: When you sign up,
19 you're directed to the portal and it says download
20 this ORM if you want a written copy. It's there
21 available to you or you can just page through it
22 right now.

23 DR. MUNSON: So, if we logged
24 into the portal, we could get to that but, then, we
25 would have to go through it to find what requires a

1 PA.

2 DR. DAVIS: Right. Right.

3 DR. MUNSON: Okay. And, so, I
4 think that that's part of the problem is that, yes,
5 it is on the portal, but, like you said, it is buried
6 and it's just not as easily accessible and that's why
7 unfortunately the only one I found was Avesis.

8 So, that would be fantastic for
9 EyeQuest and Anthem to have that, and, then, also for
10 the other MCOs to follow suit.

11 MS. GILBERTSON: We can get that
12 step by step to Sarah to disseminate to your group.

13 DR. MUNSON: Awesome. Thank
14 you. That's all I had on that, Matt.

15 MS. ASHER: Dr. Munson, can you
16 hear me?

17 DR. MUNSON: Yes, ma'am.

18 MS. ASHER: I'm Sammie Asher.
19 I'm with Aetna Better Health of Kentucky. We
20 actually do have some Powerpoint slides to point you
21 in the right direction to get to that information on
22 our website. We do supply that information on our
23 website, not necessarily inside the portal. It's
24 there as well, but it is a little easier to get to
25 through our website.

1 So, I would like to get that
2 over to you guys, just those slides, so you will have
3 that.

4 DR. MUNSON: Correct me if I'm
5 wrong. Is Aetna still not using Avesis as their
6 vision contractor?

7 MS. ASHER: We are.

8 DR. MUNSON: I'll be honest.
9 Yours is already on the Avesis portal. So, as long
10 as there aren't any other services that Aetna
11 themselves cover that Avesis doesn't which I know
12 some of the MCOs did, usually Avesis wasn't one of
13 them. So, Avesis has kind of done it all for you.
14 So, you guys are good.

15 MS. ALLEN: Thank you, Dr.
16 Munson.

17 MS. ASHER: Great. Perfect.

18 MS. ALLEN: And, Sammie, we can
19 follow up with you offline just to make sure that
20 there's no questions, but, yes, Dr. Munson, you're
21 100% correct. Thank you.

22 DR. BURCHETT: Okay. Any other
23 discussion there?

24 If not, let's move on. The
25 next question is for Avesis. I've had some questions

1 on people that have billed the 9200 codes for medical
2 services with a refraction when indicated for various
3 conditions. The refraction has not been paid on
4 those. Is that something that is ripe or is there
5 some kind of issue there that we're not seeing?

6 DR. LEVY: No, that's not the
7 case. It hasn't changed since we've been doing it
8 over these past years.

9 So, if a provider puts in the
10 appropriate medical diagnosis and points to that
11 medical diagnosis and has the provider refraction, it
12 will pay.

13 Part of a routine eye exam we
14 incorporated include our refraction within that exam.
15 So, it's included there and it wouldn't pay, but
16 nothing has changed.

17 So, if you could, provide us
18 some instances here and let's make sure that this
19 particular provider or if there are providers, make
20 sure they're pointing in the right direction for that
21 medical diagnosis; and if not, it's a good education
22 opportunity that we can work with them, but if it's
23 not and it's something on our side, I need to know
24 that.

25 DR. BURCHETT: Okay. So, just

1 for instance, a diabetic exam billed with a 9200
2 code, that would pay refraction on that?

3 DR. LEVY: Yes, sir.

4 DR. BURCHETT: Just to be clear.
5 Okay. Sounds good.

6 And, then, the other one, Dan,
7 since you're on, this is actually something that has
8 come up in my office - the referring versus the
9 rendering providers.

10 We got an email from our rep
11 last week saying that that's no longer the case; but
12 this morning on the phone talking with one of the
13 people we call into, they said, no, that it would
14 still be denied if we didn't have it the way it was
15 before it was supposed to be fixed.

16 So, what's the true word on
17 that?

18 DR. LEVY: Nicole, do you want
19 to give us an update on that, please?

20 MS. ALLEN: Sure. So, the
21 information that you received last week was correct,
22 Dr. Burchett. The rendering provider and the
23 referring provider, they can match. We have
24 realigned our policy to align with DMS.

25 If you by any chance remember

1 the name of the individual that you spoke with at
2 Avesis, then, that way we can do some re-education
3 with the team. We are re-educating the staff.

4 So, I can see that someone may
5 have made a mistake and communicated the incorrect
6 information; but if you don't remember their name,
7 that's okay. We'll just do a re-education for
8 everyone.

9 DR. BURCHETT: I apologize. Off
10 the top of my head, I don't have it but I can reach
11 out to my billing staff and see if they've got it.

12 MS. ALLEN: Okay. If they do,
13 great. If they don't, don't worry about it. We'll
14 re-educate everyone, but, yes.

15 And there is another
16 notification that will be mailed out. It's currently
17 with all of the MCOs and DMS for approval. So, as
18 soon as we get approval, which DMS, if I may say, you
19 guys have been awesome with getting our letters
20 reviewed and back like within two or three business
21 days - it's been wonderful - but as soon as we get
22 that notice back approved, you will receive an
23 updated letter so that you have something in writing
24 from us to show you in writing that the process has
25 been revised.

And if I may also take a second to explain that we are also going back and reprocessing the claims that processed under the old policy. You don't have to resubmit anything. We'll handle it on our end. It's a simple report to identify all the claims that denied for that reason and we'll go back and reprocess them.

DR. BURCHETT: Sounds good.

Thank you. Anybody else have anything to add to that?

If not, we will move on. The next item is the followup from all of our discussions with March Visions from last TAC meeting. I just wanted to check in and see on some of the issues that have come to light, how we were doing.

And if someone would like to speak on that from March, but I think we had some trouble looking at the things here from getting contracted and what type of contracting we could do for exam medical services only without doing materials, things like that was the first item.

MS. FERRER: Hi. This is
Adrienne Ferrer. I'm the Director of Network
Development for March Vision Care, and I can say that
things have really quieted down a bit.

1 We're averaging maybe about
2 forty-five days for the contracting cycle and that
3 includes credentialing and loading the providers into
4 our system. So, we're looking really good on that.

5 There are some caveats to that
6 as there have been providers that have some language
7 issues that need to be addressed and take a little
8 bit of a longer time to work through, but, in
9 general, we're looking at about forty-five days from
10 start to finish.

11 And, yes, we are absolutely
12 contracting for exams only for medical. So, we are
13 able to do that. We do have providers that are
14 currently doing that right now - exams only. So, we
15 don't seem to be having any additional requests for
16 that or issues on that particular issue.

17 DR. BURCHETT: Okay. Any TAC
18 members have any issues there that they have
19 encountered as well or people have talked with you
20 about?

21 Hearing none, the next one is
22 billing issues that some providers have had. I know
23 initially I think we might have even had this same
24 problem with the taxonomy codes, having some issue to
25 have claims go through being denied for not having

1 the right taxonomy code.

2 I think that might have been
3 for us a portal versus a clearinghouse issue. And,
4 then, we've had some people call in and talk with us
5 about not being paid in a timely manner, I think.

6 So, any discussion there?

7 MS. KLINGELHOFFER: Hi. This is
8 Tyania Klingelhofer and I am the Director for Network
9 Service for the State of Kentucky. I have spoken to
10 many of you just recently in the past couple of
11 weeks. So, I'm happy to be here today to give you
12 some updates.

13 So, regarding the taxonomy
14 billing issues that we have encountered, there are a
15 mixture of issues for denials. So, I'm just going to
16 take it step by step.

17 Some claims are denying because
18 there is no taxonomy submitted for billing or
19 rendering or both.

20 And, then, we had a
21 configuration issue between EDI and our system and we
22 did get some assistance from our IT teams and from
23 Dr. Sawyer that helped us troubleshoot, and we have
24 found the issue and the issue was resolved as of
25 Tuesday, May 4th. So, I'm very happy to relay that

1 information to all of you today.

2 We do have a claims
3 reprocessing project that is underway. Our teams are
4 working to identify the claims that need to be
5 reprocessed due to those claim denials.

6 And, then, I do want to let
7 this team know that we are going to put an
8 enhancement on eyeSynergy that will have a hard stop
9 for providers so that we can ensure that we are
10 getting a taxonomy code submitted for both rendering
11 and billing, and, then, up front we will let you know
12 if that taxonomy matches with the State file or not.

13 So, that should alleviate a lot
14 of the claims denials that are coming in without
15 taxonomy codes.

16 As far as the payments go, we
17 do pay within thirty days - usually sooner but we'll
18 go with thirty days as our max for a majority of our
19 claims.

20 We run a check three times a
21 week for all clients that are picked up for their
22 claim if the claim is processed and ready.

23 MS. HULEN: Hi. This is Angel
24 Hulen from March. I would suspect that if there are
25 delays that they may be contributing from those

1 denials that we've seen from taxonomy. However, if
2 you have examples or things we should look into
3 beyond those denials and times being paid, then, we
4 can definitely do that.

5 MS. KLINGELHOFFER: Thank you,
6 Angel.

7 DR. COMPTON: This is Steve
8 Compton. So, am I to understand the taxonomy issue
9 is solved and we can begin using the clearinghouse
10 again?

11 MS. KLINGELHOFFER: Yes.

12 DR. COMPTON: Do we still have
13 to get on a portal and get some sort of authorization
14 number?

15 MS. KLINGELHOFFER: A
16 confirmation?

17 DR. COMPTON: Yes.

18 MS. KLINGELHOFFER: Yes.
19 Confirmations are required.

20 DR. COMPTON: Okay. That puts
21 just one more step in the process. I don't do the
22 billing. I don't think we have to do that with
23 anybody else.

24 MS. HULEN: That is our process
25 to basically hold the eligibility and benefits for

1 you and confirm them through our website.

2 DR. COMPTON: Okay. It's just
3 one more administrative step for, quite frankly, a
4 fee that's a lot less than normal anyway. So, just
5 some food for thought. If you can get around that
6 somehow and make it smoother, it would be nice.

7 DR. SAWYER: This is James
8 Sawyer. I'm using CompuLink. I don't think there's
9 any place to put that in, a confirmation number.

10 DR. COMPTON: We use CompuLink
11 as well. They just have to do something. I don't
12 know. We haven't been able to get paid with the
13 clearinghouse anyway. So, we'll have to see.

14 DR. SAWYER: Tyania and I were
15 talking about the taxonomy code doesn't show anywhere
16 in CompuLink's billing transaction screen and she
17 found that it was there. It's in the background
18 somewhere and that's kind of the same thing I'm
19 thinking on this confirmation number. I don't think
20 we're going to run into a place that there's an empty
21 box to put it in.

22 MS. FERRER; And this is
23 Adrianne. If the confirmation is not on the claim or
24 in the EDI submission, as long as it's generated in
25 our system, it will bump up against that. So, the

1 system is smart enough to know that one was
2 requested. And we always encourage the confirmation
3 because of, of course, eligibility and benefits that
4 are often used. Members sometimes go to get
5 services, these services without letting the provider
6 know, another provider know.

7 But, yeah, it will bump into
8 the system if it's not on the claim or the EDI
9 submission. So, it's still there and it will pay it
10 out accordingly.

11 DR. BURCHETT: Any other
12 discussion there? Any questions about the answers
13 they've given? Good. Thank you all.

14 The last thing we had there
15 under March Vision looks like I think last time there
16 might have been some discussion on providing a frame
17 kit. Is that something that is going to happen or
18 just not at this time?

19 MS. HULEN: Can't make any
20 promises yet. That is our goal. We would like to be
21 able to achieve that. We're working through some
22 operational pieces to see what the timing would look
23 like with that. So, just bear with us but definitely
24 still on the radar.

25 DR. BURCHETT: Okay. Thank you

1 all.

2 The next item I'm going to hold
3 for just a second because I actually have a question
4 for the Department and it goes back to the Judge's
5 ruling. Is there any news on when they're going to
6 put out the new RFP's, any kind of time line or is it
7 still too early to know anything like that?

8 MS. CECIL: It is definitely too
9 early to know. There are appeal rights to that
10 Order. So, I have a feeling this isn't over.

11 So, until something is final,
12 then, the Department will make the decision on next
13 steps.

14 DR. BURCHETT: Okay. Thank you.
15 And I've got one more question for you, too, if you
16 want to hang on just a minute.

17 We had a provider call in to us
18 and say that they have a patient who is an adult and
19 has the traditional fee-for-service Kentucky Medicaid
20 and that that adult's caseworker says that they have
21 a benefit for materials for glasses available to
22 them.

23 And we didn't know if there was
24 any kind of special waiver or anything like that that
25 would have allowed for that because traditionally

1 they don't have material benefits as an adult and we
2 didn't know if there's something out there that we
3 just didn't know about for that.

4 MS. CECIL: I'm not aware. I
5 don't know if - let me look and see if----

6 MS. GUICE: I'm on.

7 MS. CECIL: Thank you.

8 MS. GUICE: Is it adults, Dr.
9 Burchett, over twenty-one? Do you know?

10 DR. BURCHETT: Yes. I think
11 that the information was coming from their caseworker
12 but I don't think their caseworker could produce
13 exactly anything other than they said that they had
14 benefits for glasses.

15 MS. GUICE: Okay. So, it's
16 likely, without knowing anything else about the
17 individual, it's very likely that the adult has a
18 waiver and that waiver may or may not provide that
19 benefit. Certainly it's not part of the regular fee-
20 for-service.

21 The only way I can answer that
22 question for sure about that individual is to have
23 someone send me that information and let me check
24 that specific individual.

25 DR. BURCHETT: That's fine.

1 We'll reach back out and try to get some more
2 information for you, then.

3 MS. GUICE: Okay. Great.
4 Thanks.

5 DR. BURCHETT: Appreciate it,
6 Lee.

7 So, the last thing on the
8 agenda that I have and the extra questions I had
9 there - thank you all for answering those, by the way
10 - and, Steve, I think you're the one that usually
11 heads up this discussion when we have it, but the
12 last few times that contracts have been put out,
13 we've tried to send up to the MAC to have it put in
14 with them about contracting vision versus medical
15 from the avenue of us doing medical services and
16 vision services as well.

17 And since we didn't get a
18 chance to discuss it much last time before the last
19 contracts were put out, I thought we might open it
20 back up if there's a chance that new contracts would
21 be put out.

22 DR. COMPTON: Do you want my
23 comments?

24 DR. BURCHETT: Well, thoughts,
25 yes.

1 DR. COMPTON: Historically, we
2 made this recommendation a couple of years ago and,
3 then, all the different changes in contracts and
4 changes in Administration, this, that and the other.

5 We made it again about this
6 time last year to be presented to the MAC but, then,
7 everything shut down and post-dated to that, the new
8 bids were let. So, it really wasn't considered, I
9 don't think, when the bids were let.

10 I guess the example I'd use is
11 if someone has conjunctivitis, pink eye, they go to
12 the nurse practitioner. They don't bill the vision
13 plan, just different things.

14 I've just always felt like with
15 medical versus vision in the commercial world, we'd
16 bill the medical stuff to the medical insurance and
17 the vision stuff to the vision plan, but, to me,
18 there's a disconnect there - discongruity. Is that a
19 word? I can't spell it.

20 I'd like for it to be
21 considered when the new bids go out.

22 DR. BURCHETT: And I know in the
23 past, we've had issues when Medicaid was the
24 secondary payer in certain situations. Like, I think
25 cataract surgery, co-management, things like that

1 have been an issue, if I remember right.

2 DR. LEVY: Matt, is this open
3 for dialogue or is this something you're asking the
4 State?

5 DR. BURCHETT: It's something
6 we're discussing.

7 DR. LEVY: Got it.

8 DR. COMPTON: That seems to be
9 where most of our hiccups occur is when we bill
10 medical to the subcontractors. And, granted, it's
11 better than it used to be.

12 DR. BURCHETT: Well, would it be
13 something that we would want to entertain making a
14 motion to send it back to the MAC in case there are
15 new contracts let?

16 DR. COMPTON: What does Dr.
17 Munson and Dr. Sawyer and Dr. Upchurch think?

18 DR. MUNSON: I guess if you look
19 at historically when we just had the Department for
20 Medicaid Services paying claims, what we refer to as
21 traditional Medicaid, the question would be did some
22 of those issues exist? Did providers have trouble
23 getting paid for vision services versus medical
24 claims? And, then, is that something that there has
25 been more of an undue burden on either system, you

1 know, the payer or the provider?

2 And if we are running into
3 issues with that now and we didn't have them
4 previous, that's something that we might actually
5 think about.

6 So, I don't know the answers to
7 those but that would be something that would point us
8 in the right direction.

9 DR. DAVIS: This is John Davis
10 from EyeQuest. Can I opine or comment? Matt, would
11 that be all right?

12 DR. BURCHETT: Yes, that's fine.

13 DR. DAVIS: I'm trying to figure
14 out - I'm trying to understand the problem, what the
15 issue is.

16 So, you say conjunctivitis.
17 You bill the vision vendor in Kentucky. That's one
18 of the reasons they carve out all of the services to
19 the vendor. We speak your language theoretically,
20 right? So, we know what conjunctivitis is versus
21 let's say that the next patient that walks in your
22 door has a routine eye exam and let's say they need
23 glasses.

24 Well, you're going to bill all
25 those services to the same payer, I mean, right?

1 You're going to bill instead of Anthem it's EyeQuest
2 in this example.

3 So, every claim you do,
4 everything you do, your entire scope of practice is
5 billed to one entity. Doesn't that make it kind of
6 logical? That's what I'm trying to figure out - the
7 problem. What am I missing? I don't get it, I
8 guess.

9 DR. COMPTON: I brought it up
10 two or three years ago because we had a lot of
11 hiccups, a lot of issues.

12 Your PCP or your nurse prac or
13 whoever treats that patient for the same condition
14 doesn't bill vision just because vision knows what
15 conjunctivitis is. I mean, the medical plans know,
16 too. It's not the same as we do everything else.

17 If a patient has Anthem and
18 EyeMed, we bill Anthem if they're a diabetic. If
19 it's a routine, we bill EyeMed or BlueVision or
20 whatever it is.

21 DR. DAVIS: So, again, just to
22 help me understand it, so, it seems like it's a
23 burden to you all to have to bill two separate
24 entities, I mean, to figure out who gets billed for
25 that particular visit maybe.

1 I know you're used to it
2 because optometry is used to dealing with a
3 commercial eye company, a vision plan, a commercial
4 vision plan. So, it's pretty common.

5 Let me give you this example,
6 right? So, a patient comes in. They're coming in
7 for an annual visit. They want to update their
8 glasses, whatever and, I don't know, their cupping is
9 asymmetric, whatever.

10 You say let's do a baseline
11 field here just because we've never seen him before
12 or we don't know what that means. Let's go ahead and
13 run that 92250.

14 So, you do that on that
15 patient. Then, in that example, you would have to
16 split that claim, then, right? You would bill the
17 vision vendor for the 92004 and you would then bill
18 the 92250 to the medical carrier, I assume. It just
19 seems like that's more of a problem or more of a
20 hassle factor than just billing the payer, the
21 correct payer.

22 Do you know what I mean?
23 Again, I feel like I'm missing something. Sorry.

24 DR. COMPTON: I guess part of
25 it, too, is optometrists can be pretty sensitive to

1 being treated differently than the rest of the
2 medical community. When the rest of them bill one
3 entity and we bill another, I don't know, it just
4 kind of leaves a bad taste in some of us, I'd say.

5 DR. LEVY: On the agenda, Dr.
6 Compton, it says discussion with all MCOs and Vision
7 Contractors: OMD's and OD's billing to the same
8 entity.

9 I don't want to speak for Dr.
10 Davis, but you know how we do it. We treat our
11 optometrists as we treat our ophthalmologists. Being a
12 single-source payer allows for way better patient
13 compliance, continuity of care.

14 I can agree with you. There
15 were hiccups along the way. We've been with you guys
16 for a long time and we've worked out a lot of things,
17 the last being that we changed the billing system
18 being based on diagnosis-driven has made it easier
19 for everybody.

20 But to Dr. Davis' point, when
21 we look at the specialty of eye care and offering a
22 single payer, I will tell you that the optometric
23 claims coming in on the medical side and the
24 advancement and scope of care in Kentucky that you
25 are providing is vast.

1 I mean, I will say that you're
2 probably in this state producing more primary and
3 secondary and tertiary care and more of the
4 ophthalmology is staying in the surgical suite than
5 any state, and I think it is because of that single
6 source and being able to have a single payer.

7 And the other thing is we use
8 the example of nurses and PCP's. The contracts are
9 the same when it comes to provider agreements, right?
10 It's all based on the scope of care and licensure in
11 that state.

12 So, when I look at claims and I
13 look at what an optometrist is providing in Kentucky
14 that they can be able to do right then and there when
15 that patient is in their exam room is much greater
16 than when it is split out because we see it split out
17 and we see the services tend just to be routine.

18 In this case, in this state,
19 your services are so much more medically advanced
20 than other states.

21 And, again, I'm just telling
22 you based on looking at the claims because, as Dr.
23 Davis stated, all we do is look at eye care claims,
24 be they come from an ophthalmologist or a specialty
25 low-vision optometrist. We get to see all of that

1 stuff, that 5% of the body that comes in to us as a
2 single source. Be it an optometrist with that
3 taxonomy or an ophthalmologist, we treat all folks
4 the same so that you guys can provide the services
5 and get paid accordingly.

6 DR. COMPTON: And you made a
7 point. When you came in to Kentucky, you were paying
8 a lot more medical claims than you had been used to
9 paying and maybe that's what triggered the issues and
10 the original discussion. It is better now than it
11 once was.

12 DR. DAVIS: And, again, I'm not
13 speaking for Avesis but I think all of us, our intent
14 is to minimize your administrative burden and that's
15 one of the reasons we like you to just bill the one
16 entity.

17 And even to the PA stuff, the
18 prior approval stuff, I know at EyeQuest, we've got
19 that pared down to pretty much the essential very few
20 codes that require a prior approval because we just
21 don't want you to have to be bothered with it,
22 frankly, and I think Avesis does the same thing at
23 this point.

24 And, by the way, when we get a
25 PA from an ophthalmologist for whatever, an eye

1 laser, we do the same thing with them. Nothing has
2 changed. Nothing is different for ophthalmology with
3 us versus the OD's in Kentucky.

4 DR. COMPTON: And that may be a
5 concern, too. We just have to be ever vigilant.

6 DR. DAVIS: Yes, and that's
7 fair. We're aware of it.

8 DR. COMPTON: I may be confused.
9 One time we did bill Anthem for the medical and
10 EyeQuest for the routine.

11 DR. DAVIS: I don't think so.
12 If you did, you didn't get paid by Anthem. You would
13 have had to then turn that claim around.

14 DR. COMPTON: I wouldn't place
15 any bets on that, okay?

16 DR. DAVIS: And, by the way,
17 just so that you know, if that happens by accident,
18 now, if an OD or one of our contracted providers
19 bills Anthem for an eye service that we cover, but we
20 have a really good system now that seamlessly
21 reverses that claim right back around to us from
22 Anthem. That might have been part of some of the
23 problem back in the day, too, because Anthem would
24 not pay it just because of whatever reason. They
25 weren't contracting with you or whatever.

1 And, so, we created a system a
2 couple of years ago which made that a really seamless
3 thing. You don't even know. And we do still get some
4 of those claims that the OD's bill to Anthem maybe
5 from habit or because their clearinghouse is set up
6 to send it to them or whatever, but, then, they flip
7 back to us and you don't even know it.

8 So, you no longer get a denial
9 from Anthem I think is what I'm saying which could
10 have been some of the friction you're talking about,
11 too, because that's annoying. Then, you say, oh,
12 shoot, we've got to bill these people now and you
13 know how that goes.

14 DR. COMPTON: Okay. I like
15 that.

16 DR. LEVY: At the end of the
17 day, John and I are both optometrists and very pro
18 optometry. I actually took this job because I was
19 quite frankly tired of just the routine eye exam
20 eight years ago.

21 I'm here doing this eight years
22 now and just the routine eye exam and not being able
23 to have that immediate continuity of care when the
24 patient is in the exam chair and that's really how we
25 developed our program. It was more optometric driven

1 than medically or ophthalmology driven when we put
2 our program together.

3 So, I do want you to keep that
4 in mind. To be able to do it the way we do it here
5 in this state and other states, you know, when we
6 were talking years ago and they were thinking about
7 that there was a lack of importance for an annual or
8 a routine eye exam and I shared with you folks that
9 we have all the medical services that come out of a
10 routine eye exam, all of those other medical
11 diagnoses, it's staggering. And where do they mostly
12 come from? Optometrists.

13 So, just keep that in mind.
14 You guys are impacting - and I can only tell you that
15 because, again, I see the claims.

16 So, when I see a routine eye
17 exam for a pair of glasses and I see the secondary,
18 tertiary and the fourth diagnosis is something else,
19 and, then, I'll go back and check in to that office
20 and see that they provide followup care for those
21 medical services that they found on an annual or
22 routine eye exam, it's amazing. I see that much
23 greater on the optometry side than I do on the
24 ophthalmology side.

25 DR. COMPTON: So, I think we

1 just leave this and we may discuss it again in a year
2 and we'll see how it goes.

3 DR. BURCHETT: That's what I was
4 going to suggest, Steve. Let's just table this and
5 revisit it if we need to in the future. Fair enough?

6 And thank you all for the
7 dialogue on that. It's much appreciated. We always
8 like to try to have open lines of communication with
9 you.

10 So, I'll just ask the TAC if
11 there's any other items that they had that didn't
12 make it on the agenda that might be able to be fixed
13 real quick, a yes or no answer or something like that
14 before we get ready to dismiss here?

15 DR. MUNSON: Hey, Matt, it's
16 Karoline. I do have two questions, one that I was
17 absent for the meeting when Durysta was brought up.

18 I know that since that meeting
19 which was two meetings ago, the State has added it to
20 the Covered Services' list, and all of the MCOs said
21 as long as it's on the Covered Services' List, that
22 that is something that they would be covering.

23 So, the question, then, because
24 there is an expense to it, it kind of goes back to my
25 old question about prior authorizations which I would

1 assume that would need, and, then, if all of the MCOs
2 have also assigned their reimbursement amount for
3 that.

4 So, in looking at the PA or
5 post-authorizations, if they could also make sure
6 that that has been added to their list and, then,
7 that there's a reimbursement assigned to that.
8 That's one thing.

9 And if any MCOs have a comment
10 or already know that answer, that's great; but if
11 not, if that could be added.

12 DR. DAVIS: I'm sorry. What was
13 the code?

14 DR. MUNSON: It's for Durysta.

15 DR. DAVIS: Oh, Durysta. Oh,
16 yes. Okay.

17 MS. ALLEN: Dr. Munson, can you
18 give us the procedure code if you have it?

19 DR. MUNSON: Not off the top of
20 my head.

21 DR. LEVY: Nicole, we're all set
22 up. We're all set. There's a clinical protocol and
23 guideline written already and we've already come up
24 with a price point. And, Karoline, I'm not sure.
25 I'm pretty sure it's on our fee schedule. I know

1 Lorenetta is on. Lorenetta, is it on our fee
2 schedule? Are you there?

3 MS. ALLEN: I don't think
4 Lorenetta is on, Dr. Levy.

5 DR. LEVY: Oh, okay. I thought
6 I saw her name on. We can get back to you on that
7 but I wrote the clinical protocol and guideline for
8 it.

9 So, I'm pretty sure it's on
10 there and I know we had to do a little research to
11 come up with a fee because there really wasn't a fee
12 but I'm almost sure it was added, but we can
13 certainly get back to you on that.

14 DR. MUNSON: Yes, because this
15 one I have doesn't have any J codes on it and I know
16 there's two codes that go with it.

17 DR. LEVY: You're right. You're
18 right.

19 DR. MUNSON: So, I'll have to
20 see if there is a new one on the portal that has that
21 added to it.

22 DR. LEVY: Okay.

23 DR. DAVIS: Dr. Compton brought
24 that up at the last meeting and we did take action on
25 that. I have to check the status on it, though. So,

1 I'll make sure I follow up with that myself for
2 EyeQuest.

3 DR. MUNSON: Okay. Thank you
4 all.

5 And, then, one other question
6 and I don't know if this is an Avesis question or a
7 WellCare question, and this came to my attention
8 yesterday for a patient calling in that WellCare
9 only, not the other MCOs that Avesis services, is
10 providing a benefit for their adults.

11 It is \$150 for glasses or
12 contact lenses and that is something that I just want
13 to see if someone could speak to as far as if that
14 covers a fitting fee and if there's anywhere they can
15 point me to some better direction on it.

16 We were told that we had to add
17 a benefit grid to our website which that didn't make
18 any sense to me either. So, if there's any
19 information that can be given about that, I'd
20 appreciate it.

21 DR. LEVY: So, we can get that
22 to you or we can share it here, but it is a \$150
23 benefit. It's a value-added benefit for that adult
24 population and the CLEFUP - contact lens evaluation
25 followup - I love that acronym - is not covered. So,

1 you would be able to use that pool of money for
2 either their eye wear and/or their contact lenses but
3 the fitting would be on the member. Do I have that
4 right, Nicole?

5 MS. ALLEN: Yes, you have it
6 right.

7 DR. MUNSON: And, so, is that a
8 straight dollar amount as far as reimbursement? So,
9 if we bill \$150, we are reimbursed \$150?

10 DR. LEVY: You are not, no. The
11 member has \$150 for them to allocate. You are
12 reimbursed a different amount of that, a percentage
13 of that. And, again, we could get you that plan
14 sheet if you don't have it.

15 DR. MUNSON: I would love that.

16 DR. LEVY: Okay. You've got it.

17 DR. MUNSON: And is that
18 reimbursement, the allocated amount or percentage, is
19 that the same percentage whether they choose glasses
20 or contact lenses?

21 DR. LEVY: That is correct.

22 That is correct.

23 DR. MUNSON: Okay. That was the
24 only thing that was new and we were trying to make
25 sure that we answer that patient's question when they

1 call to schedule their appointment. So, thank you
2 for that.

3 DR. LEVY: Okay. We'll get
4 that over to you today.

5 DR. MUNSON: Okay. Thank you.

6 MS. ALLEN: Dr. Munson, we'll
7 get you the WellCare plan sheet and, then, we'll also
8 get it over to Sarah.

9 DR. MUNSON: Okay. Excellent.
10 And, then, one other thing someone with more
11 resources than me, I can give you guys the two codes
12 for Durysta. The J code is J3490 and, then, the
13 procedure code is 96372.

14 MS. ALLEN: Thank you.

15 DR. MUNSON: That's all I had,
16 Matt. Thank you.

17 DR. BURCHETT: Sounds good.
18 Anybody else?

19 If not, then, I will entertain
20 a motion to adjourn.

21 DR. MUNSON: I make a motion
22 that we adjourn.

23 DR. UPCHURCH: Second.

24 DR. BURCHETT: Thank you all.

25 MEETING ADJOURNED